OFFICE OF SECRETARY OF STATE
PROFESSIONAL LICENSING BOARDS DIVISION
GEORGIA BOARD OF NURSING

237 Coliseum Drive
Macon, Georgia 31217
(478) 207-2440

CONSENT FORM

I hereby authorize the Georgia Board of Nursing ("Board") to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

_____
Full Name (Print)

_____

_____
Physical Address (P.O. Boxes NOT Accepted)

_____ _____ _____ _____
Sex **Race** **Date of Birth** **Social Security Number**

One of the following must be checked:

☐ This authorization is valid for 90/180/___ (circle one) days from date of signature.

☐ I, _____ give consent to the Board to perform periodic criminal history background checks for the duration of my licensure with this state.

_____ _____
Signature of Applicant **Date**

Special licensure provisions (check if applicable):

____ Working with mentally disabled
____ Working with elder care
____ Working with children